CLIENT NAME	REASSESSMENT DATE	BRANCH	TIME IN: _______ TIME OUT: _______

HOMEBOUND REASON (check one): ☐ Dependent on adaptive device(s) ☐ Requires assistance to ambulate ☐ Severe pain ☐ Medical Restrictions
☐ Severe SOB with ______________________________ ☐ Other (specify)______________________________
(MANDATORY) **UNABLE TO LEAVE HOME SAFELY DUE TO:** ____

MEDICATIONS REVIEWED? ☐ Yes ☐ No
COMPLIANT WITH MED REGIMEN? ☐ Yes ☐ No

ANY NEW/CHANGED MEDICATIONS? ☐ Yes ☐ No **If Yes,** Medication profile updated? ☐ Yes ☐ No
If Yes, document change: ______________________________

VITAL SIGNS	PAIN
BP: ____/____ ☐ *Sitting* ☐ *Standing* ☐ *Supine*	0 1 2 3 4 5 6 7 8 9 10 — No pain, Mild pain, Moderate pain, Severe — _____/10
BP: ____/____ ☐ *Sitting* ☐ *Standing* ☐ *Supine*	
Pulse: ____ ☐ Regular ☐ Irregular	Pain Location: ______________________________
	Pain Description: ______________________________
Oxygen Saturation: ____%	Aggravating Factors: ______________________________
	Alleviating Factors: ______________________________

Client is still receving services of: ☐ SN ☐ PT ☐ OT ☐ ST ☐ HHA ☐ Other: ______________________________

GROOMING	**Goal Met?** ☐ **Yes** ☐ **No**	
Comments:		
UPPER BODY DRESSING	**Goal Met?** ☐ **Yes** ☐ **No**	
Comments:		
LOWER BODY DRESSING	**Goal Met?** ☐ **Yes** ☐ **No**	
Comments:		
TOILET TRANSFERRING	**Goal Met?** ☐ **Yes** ☐ **No**	
Comments:		
BATHING	**Goal Met?** ☐ **Yes** ☐ **No**	
Comments:		
DYSPNEA	**Goal Met?** ☐ **Yes** ☐ **No**	**Patient will demonstrate increased endurance/tolerance with ability to ______________________________ with no signs or symptoms of breathlessness.**
Comments:		
PAIN INTERFERING	**Goal Met?** ☐ **Yes** ☐ **No**	**Patient will demonstrate effective pain control through ______________________, reducing pain from __/10 to __/10, allowing for ______________________**
Comments:		
OBJECTIVE MEASURE	**Goal Met?** ☐ **Yes** ☐ **No**	
Comments:		
MEDICATION MANAGEMENT	**Goal Met?** ☐ **Yes** ☐ **No**	
Comments:		
HEP COMPLIANCE	**Goal Met?** ☐ **Yes** ☐ **No**	**Patient will demonstrate ability to perform Home Exercise Program independently, or with assist of caregiver, resulting in improvements in ______________________**
Comments:		
HOSPITALIZATION PREVENTION	**Goal Met?** ☐ **Yes** ☐ **No**	**Patient will understand how and when to contact Recover Health clinicians, and will demonstrate ability to maintain medical condition in home without unplanned hospitalization or ER visit.**
Comments:		
OTHER	**Goal Met?** ☐ **Yes** ☐ **No**	
Comments:		

Provide SUMMARY of care and JUSTIFICATION as to why the client benefited from skilled therapy services. Relate the resultes to functional outcomes. Document skilled therapy performed today. Discuss Discharge Plan for continued client success.

OCCUPATIONAL THERAPY **should continue due to:** ☐ Pt potential to improve materially in a reasonable & generally predictable period of time based on the POC
☐ An OT's skills/knowledge are needed to design/establish a safe maint. Program ☐ An OT's skills/knowledge are needed to perform a safe maint. program

Supervisory Visit for: ☐ **OTA** ☐ **HHA** Is He/She **Present?** Yes No	**Following Care Plan?** ☐ Yes ☐ No **Client/Caregiver Satisfied with Service?** ☐ Yes ☐ No	☐ **Plan Of Care Reviewed/Revised with Client/Caregiver Involement**

CLIENT SIGNATURE:

Therapist Signature & Professional Designation: ______________________ **Date:** __________ **Time:** ______

CLIENT NAME	SERVICE DATE	BRANCH

Code the patient's usual performance at evaluation for each activity using the 6-point scale. If activity was not attempted at evaluation, code the reason. Code the patient's discharge goal(s) using the 6-point scale. Use of codes 07, 09, 10 or 88 is permissible to code discharge goal(s).

Safety and Quality of Performance – If helper assistance is required because patient's performance is unsafe or of poor quality, score according to amount of assistance provided.
Activities may be completed with or without assistive devices.
06.**Independent** – Patient completes the activity by him/herself with no assistance from a helper
05.**Set-up or clean-up assistance** – helper sets up or cleans up; patient completes activity. Helper assists only prior to or following the activity.
04.**Supervision or touching assistance** – Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently.
03.**Partial/moderate assistance** – Helper does LESS THAN HALF the effort. Helper lifts, holds or supports trunk or limbs and provides, but provides less than half the effort.
02.**Substantial/maximal assistance** – Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
01.**Dependent** – Helper does ALL of the effort. Patient does none of the effort to complete the activity. Or, the assistance of 2or more helpers is required for the patient to complete the activity.
If activity was not attempted, code reason
07.**Patient Refused**
09.**Not applicable** – not attempted and the patient did not perform this activity prior to the current illness, exacerbation or injury.
10.**Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints)
88.**Not attempted due to medical conditions or safety concerns**

Evaluation Score	Discharge Goal	Today's Reassess-ment Score	
			Eating: The ability to use suitable utensils to bring food and / or liquid to the mouth and swallow food and/or liquid once the meal is placed before the patient.
			Oral Hygiene: The ability to use suitable items to clean teeth. Dentures (if applicable): the ability to remove and replace dentures from and to the mouth, and manage equipment for soaking and rinsing them.
			Toileting Hygiene: The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing equipment.
			Shower/bathe self: The ability to bathe self, including washing, rinsing, and drying self (excludes washing of back and hair). Does not include transferring in/out of tub/shower.
			Upper Body Dressing: The ability to dress and undress above the waist; including fasteners, if applicable.
			Lower Body Dressing: The ability to dress and undress below the waist; including fasteners; does not include footwear.
			Putting on/taking off footwear: The ability to put on and take off socks and shoes or other footwear that is appropriate for safe mobility, including fasteners, if applicable.

Comments:

Functional Areas	Evaluation Level of Function	Goal Level of Function	Current Level of Function	Scoring Key: **The level of ability refers to the level of assistance (if any) that the patient requires to *SAFELY* complete a specified task.**
Grooming: Current ability to tend safely to personal hygiene needs (specifically: washing face and hands, hair care, shaving or make up, teeth or denture care, or fingernail care).				0 = Able to groom self unaided, with or without the use of assistive devices or adapted methods. 1 = Grooming utensils must be placed within reach before able to complete grooming activities. 2 = Someone must assist the patient to groom self. 3 = Patient depends entirely upon someone else for grooming needs.
Current **Ability to Dress Upper Body** safely (with or without dressing aids) including undergarments, pullovers, front-opening shirts and blouses, managing zippers, buttons, and snaps:				0 = Able to get clothes out of closets and drawers, put them on and remove them from the upper body without assistance. 1 = Able to dress upper body without assistance if clothing is laid out or handed to the patient. 2 = Someone must help the patient put on upper body clothing. 3 = Patient depends entirely upon another person to dress the upper body.
Current **Ability to Dress Lower Body** safely (with or without dressing aids) including undergarments, slacks, socks or nylons, shoes:				0 = Able to obtain, put on, and remove clothing and shoes without assistance. 1 = Able to dress lower body without assistance if clothing and shoes are laid out or handed to the patient. 2 = Someone must help the patient put on undergarments, slacks, socks or nylons, and shoes. 3 = Patient depends entirely upon another person to dress lower body.

CLIENT NAME	SERVICE DATE	BRANCH

Toilet Transferring: Current ability to get to and from the toilet or bedside commode safely and transfer on and off toilet/commode.				0 = Able to get to and from the toilet and transfer independently with or without a device. 1 = When reminded, assisted, or supervised by another person, able to get to and from the toilet and transfer. 2 = Unable to get to and from the toilet but is able to use a bedside commode (with or without assistance). 3 = Unable to get to and from the toilet or bedside commode but is able to use a bedpan/urinal independently. 4 = Is totally dependent in toileting.
Bathing: Current ability to wash entire body safely. **Excludes grooming (washing face, washing hands, and shampooing hair).**				0 = Able to bathe self in shower or tub independently, including getting in and out of tub/shower. 1 = With the use of devices, is able to bathe self in shower or tub independently, including getting in and out of the tub/shower. 2 = Able to bathe in shower or tub with the intermittent assistance of another person: (a) for intermittent supervision or encouragement or reminders, OR (b) to get in and out of the shower or tub, OR (c) for washing difficult to reach areas. 3 = Able to participate in bathing self in shower or tub, but requires presence of another person throughout the bath for assistance or supervision. 4 = Unable to use the shower or tub, but able to bathe self independently with or without the use of devices at the sink, in chair, or on commode. 5 = Unable to use the shower or tub, but able to participate in bathing self in bed, at the sink, in bedside chair, or on commode, with the assistance or supervision of another person. 6 = Unable to participate effectively in bathing and is bathed totally by another person.
When is the patient dyspneic or noticeably **Short of Breath**?				0 = Patient is not short of breath 1 = When walking more than 20 feet, climbing stairs 2 = With moderate exertion (for example, while dressing, using commode or bedpan, walking distances less than 20 feet) 3 = With minimal exertion (for example, while eating, talking, or performing other ADLs) or with agitation 4 = At rest (during day or night)
Frequency of Pain Interfering with patient's activity or movement:				0 = Patient has no pain 1 = Patient has pain that does not interfere with activity or movement 2 = Less often than daily 3 = Daily, but not constantly 4 = All of the time
Objective Measure				**Forward Functional Reach Test (FFRT): (3)** Unwilling to reach = risk of falling 8x > norm; **(2)** <6" = risk of falling 4x > norm; **(1)** 6"-10" = risk of falling 2x > norm; **(0)** ≥ 10" = low risk of falling **Sitting Forward Functional Reach Test (SFRT):** 40-59 y.o. **(0)** ≤ 15.9" and **(1)** > 15.9"; 60-79 y.o. **(0)** ≤ 13.2" and **(1)** > 13.2"; 80-97 y.o. **(0)** ≤ 12.5" and **(1)** > 12.5" **Other:**
Management of Oral Medications: Patient's current ability to prepare and take all oral medications reliably and safely, including administration of the correct dosage at the appropriate times/intervals. **Excludes injectable and IV medications. (NOTE: This refers to ability, not compliance or willingness.)**				0 = Able to independently take the correct oral medication(s) and proper dosage(s) at the correct times. 1 = Able to take medication(s) at the correct times if: (a) individual dosages are prepared in advance by another person; OR (b) another person develops a drug diary or chart. 2 = Able to take medication(s) at the correct times if given reminders by another person at the appropriate times 3 = Unable to take medication unless administered by another person. NA = No oral medications prescribed.

Comments:

ANALYSIS / CARE PLANNING / TREATMENT

Instruction provided this date: ☐ Safety training
☐ Exercise ☐ Other: ______________________________
☐ Equipment Needs: ________________________________

☐Client appropriate for additional services; Need verbal orders
☐ Refer to ________________________________ for evaluation.

DISCHARGE PLANNING DISCUSSED WITH: ☐ Client
☐ Family ☐ Physician ☐ Care Manager
☐Other (specify)
____

CARE COORDINATION: ☐ Physician ☐ SN ☐ PTA ☐ OT
☐ ST ☐ HHAide ☐ ALF Staff ☐ Other: ______________

APPROXIMATE NEXT VISIT DATE: ____/____/____

GOALS FOR OCCUPATIONAL THERAPY

CLIENT/CAREGIVER'S DESIRED OUTCOMES FROM O.T.: